

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
 LAST FIRST MI
 SEX: MALE FEMALE BIRTHDATE ____/____/____
 COUNTY _____ SCHOOL _____ GRADE _____
 PARENT NAME _____ PHONE NO. _____
 OR GUARDIAN ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type														
Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr	
1									1					
2									2					
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr	
4										_____	_____	_____	_____	
5										_____	_____	_____	_____	

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
 Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
 Signature Title Date

3. _____
 Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
 Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

The above child has a valid medical contraindication to being immunized at this time.

This is a permanent condition temporary condition until ____/____/____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed: _____ Date _____
 Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
Address (Number, Street, City, State, Zip)			Phone No.	
Parent/Guardian Names				
Where do you usually take your child for routine medical care?			Phone No.	
Name:		Address:		
When was the last time your child had a physical exam? Month			Year	
Where do you usually take your child for dental care?			Phone No.	
Name:		Address:		
ASSESSMENT OF STUDENT HEALTH To the best of your knowledge has your child any problem with the following? Please check				
	Yes	No	Comments	
Allergies (Food, Insects, Drugs, Latex)				
Allergies (Seasonal)				
Asthma or Breathing Problems				
Behavior or Emotional Problems				
Birth Defects				
Bleeding Problems				
Cerebral Palsy				
Dental				
Diabetes				
Ear Problems or Deafness				
Eye or Vision Problems				
Head Injury				
Heart Problems				
Hospitalization (When, Where)				
Lead Poisoning/Exposure				
Learning problems/disabilities				
Limits on Physical Activity				
Meningitis				
Prematurity				
Problem with Bladder				
Problem with Bowels				
Problem with Coughing				
Seizures				
Serious Allergic Reactions				
Sickle Cell Disease				
Speech Problems				
Surgery				
Other				
Does your child take any medication? No Yes Name(s) of Medications: _____				
Is your child on any special treatments? (nebulizer, epi-pen, etc.) No Yes Treatment _____				
Does your child require any special procedures? (catheterization, etc.) No Yes				
Parent/Guardian Signature _____			Date: _____	

PART II - SCHOOL HEALTH ASSESSMENT
To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
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1. Does the child have a diagnosed medical condition?
No Yes _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
No Yes _____

3. Are there any abnormal findings on evaluation for concern?
Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider or a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.
No Yes _____
(A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
No Yes _____

7. Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART II - SCHOOL HEALTH ASSESSMENT - continued
To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) _____ has had a complete physical examination and has:

- no evident problem that may affect learning or full school participation - problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	Date